## ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

**HEALTH CARE PROVIDER:** COMPLETE ALL ITEMS BELOW, SIGN AND DATE. THANK YOU!

### Asthma Medication(S) To Be Given:

**Student's Asthma Severity Classification:**

- [ ] Intermittent
- [ ] Mild Persistent
- [ ] Moderate Persistent
- [ ] Severe Persistent

**Exercise Pre-treatment:**

- [ ] Not Required
- [ ] Before Recess
- [ ] Before PE/Sports

**Give (Circle One):**

- **Albuterol MDI 90 / Xopenex MDI 45**
  - [ ] Puffs Inhaled (by mouth)  
  - [ ] 10-15 minutes before exercise  
  - [ ] with spacer

- **Nebulized Albuterol 2.5mg/Xopenex 0.63mg**
  - [ ] Vial inhaled (by mouth)  
  - [ ] 10-15 minutes before exercise  
  - [ ] with nebulizer

**OTHER:**

- _______________________________

**RESCUE MEDICINE TO RELIEVE ASTHMA SYMPTOMS: COUGH, CHEST TIGHTNESS, WHEEZING**

(Follow CAUTION or DANGER ZONES of Asthma Action Plan)

**Give (Circle One):**

- **Albuterol MDI 90 / Xopenex MDI 45**
  - [ ] Puffs Inhaled (by mouth)  
  - [ ] every ___ hours  
  - [ ] with spacer

- **Nebulized Albuterol 2.5mg**
  - [ ] Vial inhaled (by mouth)  
  - [ ] every ___ hours  
  - [ ] nebulizer

**OTHER:**

- _______________________________

* If there is no improvement 20 minutes after taking the Rescue Medication: Notify provider

**HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a**

**Side Effect(s) to watch for:**

- Nervousness, Shaking, Palpitations, Headache ________________________________
- [ ] None

**Reaction to/or negative interaction with food or drugs:**

- ________________________________
- [ ] None

**Self-Administration Authorization:**

- [ ] This student is capable to safely and properly self-administer medication(s)
- [ ] This student is not approved to self-administer medication(s)

**Medication Start/End Dates (one year max)**

- Start: ___/___/____
- End: ___/___/____

**Parent/Guardian Consent:**

- [ ] I authorize the student to possess and self-administer medication as described and directed above
- [ ] I authorize this medication to be administered by school personnel as described and directed above
- [ ] I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.
- [ ] I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- [ ] I assume full responsibility for providing the school with the prescribed medication and spacer.
- [ ] I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

**Parent Signature:** ____________________________  Date: ________________

**Name of Individual Receiving Written Authorization and Medication:**

______________________________  Title/Position: __________________________

**Print & Sign**

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**Note:** This form is a sample in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v).
Asthma Action Plan & Medication Authorization

GO ZONE – You’re Doing Well!  

If you have all of these:
- Breathing is good
- No cough or wheeze
- Sleep well at night
- Can work and play

TAKE THESE MEDICINES EVERYDAY

<table>
<thead>
<tr>
<th>CONTROLLER MEDICINE (Dose/Route)</th>
<th>HOW MUCH</th>
<th>HOW OFTEN</th>
<th>WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _____________________________</td>
<td>________</td>
<td>________</td>
<td>AM/PM</td>
</tr>
<tr>
<td>2. _____________________________</td>
<td>________</td>
<td>________</td>
<td>AM/PM</td>
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<tr>
<td>3. _____________________________</td>
<td>________</td>
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<td>AM/PM</td>
</tr>
<tr>
<td>4. _____________________________</td>
<td>________</td>
<td>________</td>
<td>AM/PM</td>
</tr>
</tbody>
</table>

CAUTION ZONE: –  CONTINUE WITH EVERYDAY MEDICINE and ADD RESCUE MEDICINE  

SLOW DOWN!

If you have any of these:
- First signs of a cold
- Exposed to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

DO THIS:  

Give (Circle One):

Albuterol MDI 90 or Xopenex MDI 45 _____ Puffs Inhaled □ every ___ hours □ with spacer (by mouth)

Nebulized Albuterol 2.5mg _____ Vial inhaled □ every ___ hours □ nebulizer

OR Nebulized Xopenex 0.63mg (by mouth)

*CALL YOUR HEALTH PROVIDER IF:
- There is no improvement 20 minutes after taking the Rescue Medication

DANGER ZONE – GET HELP!  

If your Asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can’t talk well
- Getting nervous

TAKE THESE MEDICINES and CALL your provider now

<table>
<thead>
<tr>
<th>MEDICINE (Circle med)</th>
<th>HOW MUCH</th>
<th>HOW OFTEN/WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Albuterol MDI 90 / Xopenex MDI 45</td>
<td>________ Puffs Inhaled □ with spacer</td>
<td>NOW!</td>
</tr>
</tbody>
</table>

2. Nebulized Albuterol 2.5mg/Xopenex 0.63mg _______ 1 vial inhaled   NOW! |

*Call your Health Care Provider NOW, if they are not available,  
Go to the emergency room or call 911 and bring this form with you.  
DO NOT WAIT!

Parent/Guardian: Make an appointment with your health care provider within 2 days of an ED visit, hospitalization, or anytime for ANY problem or question

Prescriber Signature  Date  Parent/Guardian Signature  Date

Nurse  Date